Superior Court of the State of Washington
for Snohomish County

SNOHOMISH COUNTY
ADULT DRUG TREATMENT COURT

JOSEPH P. WILSON
JUDGE
DEPT. 7

SNOHOMISH COUNTY
COURTHOUSE
M/S #502
3000 Rockefeller Avenue
Everett, WA 98201-4060
(425) 388-3421 (425) 388-3536

DRUG COURT COORDINATOR
Karla Benjamin
(425) 388-3546
Fax (425) 388-3597
Laura Whitaker
(425) 388-3093
Fax (425) 388-3597

THIS COMPLETED FORM MUST BE FAXED BY THE HEALTHCARE PROVIDER DIRECTLY TO YOUR TREATMENT PROVIDER OR DRUG COURT COORDINATOR
EMI FAX: (425) 263-9706 CCS FAX: (425) 258-5276 DCC FAX: (425) 388-3597

Snohomish County Superior Court Adult Drug Treatment Court
MEDICATION FORM

1. I have been diagnosed as an "addict" or "substance dependent", and I'm participating in chemical dependency treatment through Snohomish County's Adult Offender Drug Court.
   - **As part of my treatment, I am to avoid drugs generally problematic for me, including:**
   - **narcotic analgesics** (e.g. Vicodin, Percoset, hydrocodone)
   - **sedative hypnotics** (inc. benzodiazepines and barbiturates)
   - **tramadol/ultram**
   - **muscle relaxants**
   - **prescription or over-the-counter stimulants (including ephedrine, pseudoephedrine, etc.)**
     Please recommend or prescribe alternatives for me.

2 I must submit to regular urinalysis testing, and I am not permitted to use any prescribed medications except under the direct supervision of a physician.

3. If you believe it is **a medical necessity** to prescribe me any pain medication, mood altering drug or any medication with a potential to become habit-forming, please complete this form. **Please prescribe such medications for the shortest duration possible**. I will then submit it to drug court.

Note: ***Except in the event of a medical emergency, please have this form completed and turned in to your treatment provider 7 days prior to prescribing any mood altering medications (as listed above). If you have been discharged from treatment, you are required to fax this completed form to your Drug Court Coordinator.*** The Drug Court Team reserves the right to deny entry to candidates or terminate participants who are taking legally prescribed mind and/or mood altering drugs.

Health Care Provider

1. Client Name:_____ Please Print

2. The **CURRENT DIAGNOSIS** is:

_____ _____
Diagnosis Date of Onset

3. I understand the patient is chemically dependent but I have nevertheless written a prescription for the following medication for the purpose indicated:

_____ _____ _____
Medication Dosage Length of time client is to remain on this medication (days, weeks, months)

_____
Intended purpose

_____ _____
Physician signature Date signed

_____ _____
Printed name of physician/health care provider Phone number

HEALTH CARE PROVIDER: **PLEASE ATTACH BUSINESS CARD**

✷ ✷

Participant signature required on the other side of this form

I, as the patient receiving prescribed medications, understand the following:

- If lost or stolen, I will need to obtain a new prescription and have a new form completed.
- This prescription may ONLY be used for the current diagnosis and MAY NOT be used for any other purpose. If this or a new condition arises in the future, a new prescription and form are needed.
- Except in the event of an emergency, I may have prescriptions dispensed from ONE health care provider ONLY and ONE pharmacy ONLY.
- It is understood that I will utilize non-addictive pain management WHENEVER possible, and that I will not use any illegal drugs or drugs which have not been lawfully prescribed to me.
- ANY misuse of my prescription, failure to provide this form, or misuse or falsification of this form may result in sanctions and be grounds for termination from the ADTC program.

I certify (or declare) under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Participant Signature: _____

Signed on _____ in _____, State of Washington
(Date) (City or town)